Provider Insider

Alabama Medicaid Bulletin **May 2002**

The checkwrite schedule is as follows:

05/03/02 05/17/02 06/07/02 06/21/02 07/05/02 07/19/02 08/02/02 08/16/02 09/06/02 09/13/02

As always, the release of direct deposits and checks depends on the availability of funds.

Medicaid Offers Clarification on Billing for Bilateral Procedures

There are two kinds of bilateral procedures. These procedures are 1) designated as bilateral in the CPT and 2) not designated as bilateral since they can be performed unilaterally or bilaterally. When billing for designated bilateral procedures, the provider must bill one unit on a single line item **without** modifier "50" since the procedure code itself is bilateral, and bill the **total charged amount**. An example is demonstrated below:

DATE(S) OF SERVICE						Place of Service	Type Of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual circumstances)		DIAGNOSIS CODE	$CHARGES	DAYS OR UNITS
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
05	01	02	05	01	02	21		19369		1	500.00	1

When billing for non-designated bilateral procedures that are performed at the same time or at the same operative session, the provider must bill one unit on a single line item **with** a modifier "50" (bilateral procedure), and bill the **total charged amount** for both procedures. These procedures require modifier "50" because they are often done bilaterally, and are not designated as bilateral in the 2002 CPT. An example is demonstrated below:

DATE(S) OF SERVICE						Place of Service	Type Of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual circumstances)		DIAGNOSIS CODE	$CHARGES	DAYS OR UNITS
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
05	01	02	05	01	02	21		15823	50	1	1600.00	1

Above is the correct procedure for billing both types of bilateral procedures. It is important that providers do **not** bill a procedure that was performed bilaterally on separate line items. The second line item **will be denied**. An example is demonstrated below:

DATE(S) OF SERVICE						Place of Service	Type Of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual circumstances)		DIAGNOSIS CODE	$CHARGES	DAYS OR UNITS
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER			
05	01	02	05	01	02	21		15823		1	800.00	1
05	01	02	05	01	02	21		15823	50	1	800.00	1

INCORRECT

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Pass It On!

Everyone needs to know the latest about Medicaid.

Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Dept.*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other _____*

EPSDT Sevices and Its Benefits

The purposes of the EPSDT program are: to actively seek out all eligible families and educate them on the benefits of preventive health care, to help recipients effectively use health resources and encourage them to participate in the screening program at regular intervals, to provide for the detection of any physical and mental problems in children and youth as early as possible through comprehensive medical screenings in accordance with program standards, and to provide for appropriate and timely services to correct or improve any acute or chronic conditions. The ages recipients should receive comprehensive screenings are: 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and annually through 20 years of age beginning with the child's 3rd birthday. To assist providers in meeting the above goals, the Agency mails a monthly report (Periodic Rescreening List) to Patient 1st and some EPSDT providers identifying recipients' birthdates and due date for their next comprehensive screening. Please use the report to schedule correspondence with recipients. For further information, please refer to Appendix A of your Provider Manual.

Interperiodic Screenings

Interperiodic screenings are problem-focused medically necessary exams performed to determine the existence of a suspected physical or mental illness or condition, regardless of whether such services coincide with the periodicity schedule. Interperiodic screenings may be performed before, between, or after a periodic screening for undiagnosed chronic conditions. Interperiodic screenings may also occur in the case of children whose diagnosed illness/condition (physical, mental, or developmental) has become more severe or has changed sufficiently, so that further examination is medically necessary. A referral to others or a self-referral may be issued for problems identified during an initial, periodic, or interperiodic screening. The four requirements for documentation are; 1) signed consent form, 2) medical/surgical history update, 3) problem-focused physical examination, and 4) anticipatory guidance/counseling related to the diagnosis made. Interperiodic screenings will have abnormal diagnoses. For more information, please refer to Appendix A of your Provider Manual.

Clarification Regarding Dental Screenings

Appendix A of the Provider Manual is being updated to clarify the policy for dental screenings. Dental care is limited to Medicaid-eligible individuals who are eligible for treatment under the EPSDT Program. Dental screenings must be performed on children from birth through age two by observation/inspection and history. Beginning with age three, recipients must be either under the care of a dentist or referred to a dentist for dental care. If the child is under the care of a dentist, the provider should simply document "under the care of a dentist," e.g., "u/c dentist". This policy has not changed. Any time a need for dental care is identified, regardless of the child's age, the child should be referred to a dentist. Beginning with age one, providers should document that caretakers have been advised of the importance (anticipatory guidance) of good oral healthcare and the need to make a dental appointment. Additional documentation suggestions include providing the caretaker with either the dentist's phone number or the Agency's Dental Program phone number to assist with locating a dentist. For additional information, please refer to Chapter 13, Dentist, of your Provider Manual.

MEDICAID Tidbits

Patient 1st Referrals and Prior Authorization Requests

An appropriate Patient 1st referral is required in addition to the PA number for recipients participating in the Patient 1st Program. Please remember to include the appropriate Patient 1st referral information in addition to the PA number when filing claims. If this information is needed and not included on the claim form, your claims will be denied.

Provider Types Added to Newborn Hearing Screens

Be aware another provider type has been added to perform newborn hearing screenings—Otolaryngologists—Head and Neck Surgery.

Cancelled or Missed Appointments

Providers should not bill recipients for cancelled or missed appointments. If a provider accepts Medicaid assignment, he or she cannot bill Medicaid or the recipient for a service he or she did not provide, i.e., "cancelled, missed, no call, or no show".

Provider Visits

Effective June 14, 2002, physician visits provided in an outpatient setting that have been certified as an emergency do not count against the physician benefit limit of 14 per calendar year.

Starred Surgical Procedures

Medicaid recognizes the CPT definition for starred (*) procedures or items.

MEDICAID Tidbits

Medicaid Policy Concerning the Release of Information

Chapter 20 of Medicaid's Administrative Code states that providers must notify the Medicaid Agency when they receive requests for a Medicaid recipient's medical records and/or copies of billings. This notification process has enabled the Medicaid Agency to save millions of dollars through identification of other resources that have reimbursed the Agency for recipients' medical bills. Providers are not required, however, to notify Medicaid of requests for the following:

a) When the information is needed for a Social Security Disability hearing or application,
b) For life insurance applications or payment of life insurance benefits;
c) As needed by a medical provider for treatment of the patient;
d) For child custody hearings
e) Requests by law enforcement personnel
f) For school athletic records
g) For any request if such records pertain to treatment or care for which Medicaid has not or will not be filed

If there are other situations that you would like clarified, please contact Zeffie Smith, Associate Director, Third Party Division, at (334)242-5302. Notification of medical records requests should be referred to Marvie Frazer at the Alabama Medicaid Agency, P. O. Box 5624, Montgomery, AL 36103-5624 or by calling (334) 242-2322.

Updated ICD-9 Diagnosis Codes to be Used in 2002

The Alabama Medicaid Agency has updated its records to include the 2002 sixth edition of the ICD-9-CM diagnosis codes. As a reminder, all diagnosis codes must be carried to the highest subdivision. Effective January 1, 2002, Medicaid will only recognize codes in the 2002 sixth edition.

Medicaid Will Provide Covered Services for Pulse Oximeters

Effective April 1, 2002, pulse oximeters are a covered service for EPSDT eligible individuals who are already approved for supplemental home oxygen systems and whose blood saturation levels fluctuate, thus requiring continuous or intermittent monitoring to adjust oxygen delivery. To receive prior authorization, submit a written request to include, but not limited to, all the following requirements:

a) A completed Form 342 with required supportive documentation
b) Copy of EPSDT form/referral
c) Copy of prior approval form for home oxygen (Form 360)

For those currently not on oxygen, additional medical justification may be submitted. Approval will consist of up to three months **only**. In addition to items a and b, the following documentation is required:

d) Pulse oximetry evaluations. To qualify, recipients from birth to three years must have a SaO2 equal to or less than 94%. Recipients age four and above must have a SaO2 equal to or less than 89%. Conditions under which lab results were obtained must be specified. Pulse oximetry evaluations are acceptable when ordered and evaluated by the attending physician, and performed under his/her supervision, or when performed by a qualified provider or supplier of laboratory services. A DME supplier is not a qualified provider or supplier of lab services.
e) Plan of care. A plan of care updated within 30 days of request must be submitted to include, at a minimum, plans for training the family. The training plan shall provide specific instructions on appropriate responses for different scenarios, i.e., what to do when O2 sats are below 89%.

Renewal may be requested for patients approved for oxygen coverage by the Alabama Medicaid Agency. Documentation should also include:

· Written or printed results of pulse oximetry readings obtained within the last month with documentation of condition(s) present when readings were obtained.

Renewal may be granted for up to a six-month period for patients receiving oxygen coverage through Alabama Medicaid.

Qualifying Diagnoses for the Pulse Oximeter

1) Lung disease, including but not limited to interstitial lung disease, cancer of the lung, cystic fibrosis, bronchiectasis
2) Hypoxia related symptoms/conditions, such as pulmonary hypertension, recurrent CHF secondary to cor pulmonale, erythrocytosis, sickle cell disease, severe asthma, hypoplastic heart disease.
3) Suspected sleep apnea or nocturnal hypoxia
4) Other diagnoses with medical justification

Exclusions / Limitations for the Pulse Oximete

Diagnoses not covered:

1) Shortness of breath without evidence of hypoxemia
2) Peripheral Vascular Disease
3) Terminal illnesses not affecting the lungs, such as cancer not affecting the lungs or heart disease with no evidence of heart failure or pulmonary involvement.

Pulse oximeter requests for renewal will not be approved after the initial monitoring/evaluation period for those recipients not meeting criteria for oxygen coverage.

Billing Information for Endodontic Therapy & Treatment

Medicaid is required by Centers for Medicare and Medicaid (CMS) to conduct ongoing program monitoring of service utilization and expenditures. A review of dental provider claims has identified a problem with the billing practices of some dental providers. The Alabama Medicaid Provider Manual, Chapter 13, page 13 states that "Root canal therapy applies to permanent teeth only. Therapy includes treatment plan, clinical procedures, radiographs, and follow-up care." The ADA CDT-3 Version 2000 indicates that pulpectomy is included in "complete root canal therapy". A claims review of endodontic codes has revealed that some providers are billing other endodontic codes on the same day or on different dates of service for the same tooth number(s). Complete root canal therapy includes all appointments necessary to complete treatment, all intra-operative radiographs and other endodontic procedures considered to be integral components of the root canal therapy. Only the single most appropriate endodontic code should be billed for a particular tooth. Audits in the near future will prevent unbundling of the endodontic codes with subsequent denials of any codes considered to be "mutually exclusive". The billing of the incorrect code will result in denials of additional services requiring the denied procedures in claims history. Example, the provider bills D3220 for tooth number 06 for DOS 02/21/02 and is paid. On 03/02/02 the provider subsequently attempts to bill D3310 for tooth number 06. This procedure will deny since D3220 has previously been billed and paid. The provider will also get a denial for D2750 if subsequently billed since there is now no root canal in claims history. Also remember that these procedures and others should only be billed upon completion. Please contact the Dental Program at (334) 242-5997 if further clarification is needed.

Other Insurance Payments and Claims Documentation

UB-92 and HCFA 1500 claims that show a third party payment must also show the third party payer name (or Medicaid's 5 digit insurance company identifier) and the policy or contract number. Claims that do not meet these criteria will be denied with one of the following error codes:

1730 – Shows a third party payment. The policy number and insurance company name or code are missing.

1731 – Shows a third party payment and insurance company name or code. The policy number is missing.

1732 – Shows a third party payment and policy number. The insurance company name or code is missing.

Did You Know?

Hypoxia is defined as insufficient oxygenation of the blood. Pulse oximetry is a non-invasive method of determining blood oxygen saturation levels to assist with determining the amount of supplemental oxygen needed by the patient.

Billing for Injectable Drugs (J Codes)

Medicaid has received information from CMS that the descriptions in the HCPCS are based on recommended doses, not necessarily on what is available from the drug manufacturers. A case in point is J1626, granisetron HCl, which the HCPCS description states is "100 mcg" and to "use this code for Kytril." However, the injectable forms for Kytril both contain approximately 1 mg. of the drug per ml. Using Kytril as an example, the recommended dose is 10 mcg/kg (2002 PDR, p. 2987). A patient weighing 200 lbs. or 90.9 kg would require 909 mcg or .909 mg of the drug. Using the single dose vial, a provider should bill for 1 unit. Please ensure that the units billed for the J codes matches the information on the drug label and not necessarily what is in the HCPCS.

Notification of Insurance Updates

To notify Medicaid of new health insurance or changes in existing coverage, please contact the appropriate Medicaid staff person as indicated:

Patient's last name begins A – G
call Dolores Lucas – 334-242-5280

Patient's last name begins H – P
call Barbara Williams – 334-242-5254

Patient's last name begins Q – Z
call Mary Knight – 334-242-5279

Medicaid staff will need the recipient's name, Medicaid number, and policy information, including lapsed date if the policy is no longer in force. If you leave a voice mail message, please state clearly your name and telephone number, including area code, so that staff can contact you if there are questions. Records are normally updated within one business day of your call, and this change will be reflected in the claims processing system within 1 to 3 business days of this update.

www.medicaid.state.al.us

Alabama Medicaid

In The Know

General Information Providers Need to Know When Billing to the Alabama Medicaid Agency

Policy for coverage of External Ambulatory Infusion Pump, Insulin

Effective June 1, 2002, external ambulatory insulin infusion pumps maybe approved by the Alabama Medicaid Agency for use in delivering continuous or intermittent insulin therapy on an outpatient basis when determined to be appropriate medically necessary treatment, and prior authorized.

The following criteria will be utilized in evaluating medical necessity for the insulin pump:

- Patient must be less than 21 years of age and EPSDT eligible.
- A board certified or eligible endocrinologist must have evaluated the patient and ordered insulin pump.
- Patient must have been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the external ambulatory insulin infusion pump.
- Patient must have documented frequency of glucose self-testing an average of at least four times per day during the three months prior to initiation of the insulin pump.
- Patient or caregiver must be capable, physically and intellectually, of operating the pump.
- Type 1 diabetes must be documented by a C-peptide level < 0.5.
- Records must have documentation of active and past recipient compliance with medications and diet, appointments and other treatment recommendations.

Two or more of the following criteria must also be met:

- Copies of lab reports documenting two elevated glycosylated hemoglobin levels (HbA1c> 7.0%) within a 120-day time span, while on multiple daily injections of insulin.
- History of severe glycemic excursions (commonly associated with brittle diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements). A history of not less than 3 documented episodes of severe hypoglycemia (<60 mg/dl) or hyperglycemia (>300 mg/dl) in a given year.
- Widely fluctuating blood glucose levels before mealtime (i.e., pre-prandial blood glucose level consistently exceeds 140 mg/dl).
- Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl.

The following approved diagnoses will be given for only the following type 1 diabetes mellitus diagnosis codes, if above criteria is met:

250.01, 250.03, 250.11, 250.13, 250.21, 250.23, 250.31, 250.33, 250.41, 250.43, 250.51, 250.53, 250.61, 250.63, 250.71, 250.73, 250.81, 250.83, 250.91, 250.93.

Maximum yearly limits apply to procedure codes: E0784, A4221, A4232

Requests for replacement of E0784 will be limited to once every 5 years based on a review of submitted documentation requested.

EDS Provider Representatives

G R O U P 1

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- Nurse Practitioners
- Podiatrists
- Chiropractors
- Independent Labs
- Free Standing Radiology
- CRNA
- EPSDT (Physicians)
- Dental
- Physicians
- Optometric (Optometrists and Opticians)

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- Rehabilitation Services
  - Home Bound Waiver
- Therapy Services (OT, PT, ST)
- Children's Specialty Clinics
- Prenatal Clinics
- Maternity Care
- Hearing Services
- Mental Health/Mental Retardation
  - MR/DD Waiver
- Public Health
  - Elderly and Disabled Waiver
  - Home and Community Based Services
  - EPSDT
  - Family Planning
  - Prenatal
  - Preventive Education
- Ambulance
- FQHC
- Nurse Midwives
- Rural Health Clinic
- Commission on Aging
- DME

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- Ambulatory Surgical Centers
- ESWL
- Home Health
- Hospice
- Hospital
- Nursing Home
- Personal Care Services
- PEC
- Private Duty Nursing
- Renal Dialysis Facilities
- Swing Bed

New Information Regarding Vaccines

The Alabama Department of Public Health, Immunization Division is pleased to provide you with several points of interest regarding the Vaccines for Children Program (VFC). This information will allow you to better understand existing VFC policies and procedures.

Updated Vaccine Order Form (2/02)

The Vaccine Order Form (2/02) version should be used exclusively to order vaccine on a monthly basis. Please discard all other versions of the VFC Vaccine Order Form to avoid delay in shipping your vaccine. Because of the national vaccine shortages, CDC now requires all state VFC programs to order vaccines every 30 days. Therefore, we are implementing a 30-day maximum supply order until further notice, including varicella vaccine.

Updated Expired or Spoiled Vaccine Report (2/02)

We must remind providers that vaccine is very expensive and now hard to obtain.. For that reason, the Expired or Spoiled Vaccine Report for VFC Providers (2/02) has been updated. In every case of expired and spoiled vaccines, you must include how this will be avoided in the future. Each provider must take care of the vaccine entrusted to them to the best of their ability. Although the VFC Program advertises free vaccine to providers, in reality it cost all taxpayers. To avoid expired vaccine call VFC at 1-800-469-4599, 3-6 months before vaccine expires and VFC will redistribute it.

Important Mailing Addresses	
Pharmacy, Dental, and UB-92 claims	EDS Post Office Box 244033 Montgomery, AL 36124-4033
HCFA-1500	EDS Post Office Box 244034 Montgomery, AL 36124-4034
Inquiries, Provider Enrollment Information, Provider Relations, and Diskettes for Electronic Claims Submission (ECS)	EDS Post Office Box 244035 Montgomery, AL 36124-4035
Medicare Related Claims	EDS Post Office Box 244037 Montgomery, AL 36124-4037
Prior Authorization (to include Medical Records)	EDS Post Office Box 244036 Montgomery, AL 36124-4036
Adjustments / Refunds	EDS Post Office Box 244038 Montgomery, AL 36124-4038

REMINDER

Contact Alabama Medicaid Online

www.medicaid.state.al.us

New Requirements for UB-92 Submissions

Providers must submit an occurrence date and the appropriate occurrence code for UB 92 claims that contain one or more diagnosis codes from the range 80000 through 99499. The occurrence code and date must be entered in either field 32, 33, 34, 35, or 36. Valid values for the occurrence code are 01 through 06 for this diagnosis range. Medicaid will deny claims that do not meet this criteria. Medicaid needs the occurrence code and date to obtain reimbursement from third party payers.

Plan First Will Only Reimburse for Specific Lab Work

Plan First will only reimburse for specific lab work (see Appendix C of the Alabama Medicaid Provider Manual) and any lab work ordered prior to a tubal that is not on the list of covered services will be denied by Medicaid. It is up to the physician to inform the patient prior to rendering services, that they may be responsible for the cost of the lab work ordered outside of the Plan First Program. This includes any lab work ordered by the physician and is drawn at a facility other than the provider's office.

www.medicaid.state.al.us

Providers Can Recieve:

Enrollment Applications
Medicaid Press Releases
Provider Insiders
Forms
Billing Manuals
Provider Manuals
Medicaid Software
Checkwrite Schedules
Annual Reports
Provider Notices
General Information
Continuing Education

www.medicaid.state.al.us

Medicaid Announces a Change in the Provider Manual Distribution

The Alabama Medicaid Provider Manual is changing. Beginning with the July update, the manual will be delivered in a CD ROM format instead of a paper format. Providers will notice instant advanages to this change. They are:

- The ability to use the search function to find specific topics.
- No more updates! The entire manual will be sent each quarter.
- The manual can be loaded from the CD to multiple computers.
- The ability to go directly to a specific section by clicking on predefined bookmarks.
- The ability to print the manual or specific sections.

If you have any questions or comments concerning the new Alabama Medicaid Provider Manual format, please contact the EDS Provider Enrollment Unit at (888) 223-3630 (in-state or bordering) or (334) 215-0111 (out of state).

EDS
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